

Postpartum spontan sol ana koroner arter diseksiyonu

Postpartum spontaneous left main coronary artery dissection

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A 32-year-old female, was admitted to our hospital with midsternal chest pain during 90 minutes. She was in the postpartum 10th day. She had no known cardiovascular risk factor except smoking. She smoked 30-40 cigarettes per day and continued during pregnancy. She also had no history of connective tissue disorder or any systemic disorder. On physical examination: blood pressure was 80/60 mmHg and heart rate was 90 beat/min. Cardiovascular system examination was entirely normal. Respiratory system examination revealed that there was crepitant rales in both lungs which was pronounced in the right basal field. Electrocardiogram showed acute anterior wall myocardial infarction (Figure 1). Coronary angiography revealed a long dissection of the left main coronary artery (LMCA) that extended to both left anterior descending artery (LAD) and left circumflex artery (LCx) (Figure 2a). Right coronary artery was angiographically normal. Tirofiban infusion was admitted intravenously. A stent was implanted (5.0 x 20mm Lektom motion) to the both LMCA and LCx and inflated at 14 Atm. An 4.0 x 20 mm stent (Ephesos) was implanted to the LAD ostium and inflated at 14 Atm. Final angiogram showed no residual stenosis, no thrombus with TIMI III flow in LMCA and LCX, and TIMI II flow in LAD (Figure 2b). During the procedure she had 13 episode of ventricular fibrillation that responded to external defibrillation and amiodarone intravenously. Intra-aortic balloon pump was implanted to improve coronary blood flow. Unfortunately the patient went into cardiac arrest after transferred to coronary care unit and heart rhythm was not achieved. Coronary artery dissection is the most important reason of the pregnancy-related myocardial infarction in the postpartum period. Common cause of coronary artery dissection is not quite clear during this period. Hormonal factors are thought to be causing damage to the coronary arterial wall by increasing hemodynamic stress. The mechanisms are pregnancy-induced connective tissue damage, hemodynamic stress (especially during birth), rupture of vasa vasorum and eosinophilia. The patient's hemodynamic status and extent of myocardial injury are important factors to be considered during treatment. Patients recovered with conservative treatment are available in the literature. A patient with poor hemodynamics, extensive myocardial damage and with no response to medical therapy may go under percutaneous coronary intervention. Anatomically complex cases may benefit from coronary artery bypass surgery.



Figure 1: Electrocardiogram

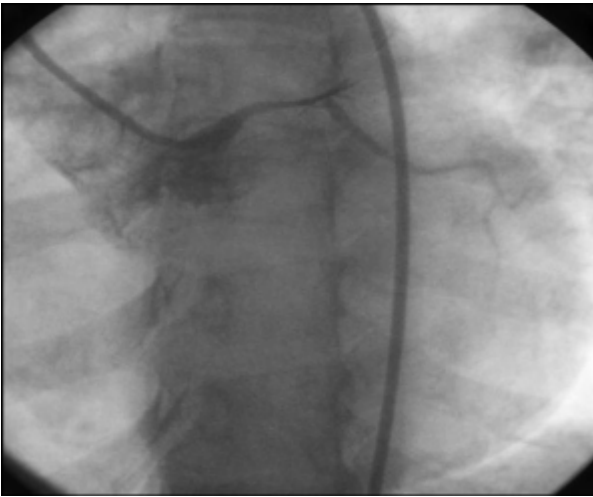


Figure 2a: Left anterior oblique caudal view of left coronary angiogram



Figure 2b: Right anterior oblique caudal view of left coronary angiogram